



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

JAMES E. RISCH – Governor  
KARL B. KURTZ – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7000 1670 0011 3314 9146**

August 15, 2006

M. Denise Hall, Administrator  
The Orchards Rehabilitation & Care Center  
1014 Burrell Avenue  
Lewiston, ID 83501

Provider #: 135103

Dear Ms. Hall:

On **July 25, 2006**, a fire safety survey was conducted at The Orchards Rehabilitation & Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2).** After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 28, 2006**. Failure to submit an acceptable PoC by **August 28, 2006**, may result in the imposition of civil monetary penalties by **September 18, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 29, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 29, 2006**. A change in the seriousness of the deficiencies on **August 29, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 29, 2006** includes the following:

Denial of payment for new admissions effective **October 25, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 1, 2007**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

M. Denise Hall, Administrator  
August 15, 2006  
Page 3 of 3

3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 25, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 28, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

[http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001\\_10.pdf](http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10.pdf)  
[http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001\\_10\\_attach1.pdf](http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10_attach1.pdf)

If your request for informal dispute resolution is received after **August 28, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



MARK P. GRIMES  
Supervisor  
Facility Fire Safety and Construction

MPG/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/25/2006</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

**THE ORCHARDS REHAB & CARE CTR**

STREET ADDRESS, CITY, STATE, ZIP CODE

**1014 BURRELL AVE  
LEWISTON, ID 83501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

K 000

**INITIAL COMMENTS**

The facility is a single story, Type V(111) construction. It was built/completed in 1958. It has a large basement used for classrooms, breakroom, and maintenance shop. The building is fully sprinklered and currently licensed for 127 SNF/NF beds.

The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 24-25 July, 2006. The facility was surveyed under the LIFE SAFETY CODE, 200 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70.

The Survey was conducted by:

Chris Laumann, Health Facility Surveyor

K 000

*PLEASE ACCEPT THIS  
AS OUR plan of  
CORRECTION.* **RECEIVED**  
**AUG 29 2006**  
FACILITY STANDARDS

*8/23/06*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]* *Administrator* *8/25/06*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ORCHARDS REHAB &amp; CARE CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observations found during a facility tour it was determined that the facility failed to ensure the proper closure and latching of corridor doors. 2 of 58 residents were effected.</p> <p>The finding included:</p> <p>1.) During a facility tour of the facility on the afternoon of 25 July, 2006, between the hours of 11:00AM and 12:40 AM, the doors of rooms 202 and 225 were observed to not properly close and latch.</p> <p>Observations were witnessed and noted by</p>	K 018	<p><i>Left Blank intentionally</i></p> <p><i>Doors to Room 202 &amp; 225 have been repaired to meet Life Safety code. All other patient rooms have been checked and are</i></p>	<p><i>8/23/06</i></p>	

PRINTED: 08/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete      Event ID: ZIT621      Facility ID: MDS001760      If continuation sheet Page 3 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ORCHARDS REHAB &amp; CARE CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 027	Continued From page 3  clearance necessary for proper operation.	K 027	<b>Left Blank Intentionally</b>	<b>8/23/06</b>	
K 029 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to ensure proper door closure requirements for 3 of 3 soiled utility rooms which are considered hazardous areas. All 58 residents were effected.</p> <p>Findings include:</p> <p>Observations made between 1:34 PM and 1:50 PM on the 25 July, 2006 revealed that the doors to 3 of 3 soiled utility rooms did not secure, as they were lacking the required self closure devices. These hazardous utility rooms were located in the annex main hall, the north annex, and the end of the north annex hallway. When interviewed, staff did identify proper procedures</p>	K 029		<p><b>Self closing hinges have been applied to the 3 soiled utility rooms.</b></p> <p><b>Besides the self closing hinges the outside of the doors also have slide bolt locks to ensure patient safety. The main entrance supervisor will check all self closers to ensure proper working order on</b></p> <p><b>8/23/06</b></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ORCHARDS REHAB &amp; CARE CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 029	Continued From page 4  All findings were observed and noted by maintenance supervisor and surveyor.	K 029	his monthly audits to maintain compliance		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that the LTC staff was adequately trained to respond to fires. This potentially exposed the census of 58 residents and all staff to smoke and fire in the facility.  Findings include:  An examination of the facility's fire drill record on 25 July, 2006 revealed that fire drills were not conducted for the second and third shift in the first quarter, first shift in the second quarter, first and second shifts in the third quarter, and second and third shifts of the fourth quarter. Upon interview, 3 of 3 staff properly identified proper procedures to take in the event of a fire related emergency.	K 050	Fire drills had not been completed or documented. When I, the Administrator, became aware the Maintenance supervisor was terminated. The Corporate Office immediately sent a maintenance man from another building to assist with the lack of documentation and to train the new Maintenance supervisor. Since that time all fire drills have been completed as required and are signed off by myself to ensure compliance.	8/23/06	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ORCHARDS REHAB &amp; CARE CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 050	Continued From page 5  These observations were acknowledged by the maintenance supervisor.	K 050			
K 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility had not ensured that the sprinkler system was inspected and tested annually. This Failure affected 100% of the staff and residents.</p> <p>Findings include:</p> <p>Observation on 25 July, 2006, disclosed that the inspection tag, affixed to the riser for the sprinkler system, had been marked to show the last extinguishing system inspection had been conducted on 17 May, 2005. Review of inspection records validated the last inspection.</p>	K 056	<p>Maintenance supervisor faxed copy of sprinkler system inspection on 7/26/06. Annual inspection has been added to the maintenance supervisors Annual inspection Report to ensure compliance on an annual bases.</p> <p>Kitchen Hood inspection was completed on 7/20/06 (see attached copy). This has also been added to the Annual maintenance schedule to ensure compliance.</p>		8/23/06

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ORCHARDS REHAB &amp; CARE CTR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 056	Continued From page 6  Staff stated on 25 July, 2006 that the sprinkler servicing company had not conducted the annual service on the system.	K 056			
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain electrical panels by preventing a potential exposure to live circuits. The facility had census of 58 residents all of whom were in danger of being effected in the event a fire had started.  Findings included:  1. Two instances of exposed electrical panel circuitry was observed in the facility on 25 July, 2006, one was located in the sub electrical panel for the "DW" Freezers in basement at 11:21 AM, the other was located between the South and West wings and in the A/C heating electrical panel at 11:25 AM.  All finding were observed and noted by surveyor and maintenance supervisor.	K 147	Electrical panel plugs have been installed in the breaker panels and a cover has been replaced on the breaker box to ensure the safety of all residents & personnel. All electrical panels will be inspected on a monthly bases by the maintenance supervisor to ensure compliance.		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/25/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ORCHARDS REHAB &amp; CARE CTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p><b>INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story, Type V(111) construction. It was built/completed in 1958. It has a large basement used for classrooms, breakroom, and maintenance shop. The building is fully sprinklered and currently licensed for 127 SNF/NF beds.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 24-25 July, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Chris Laumann, Health Facility Surveyor</p>	C 000	<p><i>PLEASE accept this AS our plan of Correction</i></p>	
C 230	<p><b>02.106,02,b</b></p> <p>b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time.</p> <p>This Rule is not met as evidenced by: Refer to Federal K tags 018, 027, 029, 050, 056, and 147.</p>	C 230	<p><i>SEE F tags for plan of correction</i></p>	<p><i>8/23/06</i></p>
			<p>RECEIVED AUG 29 2006 FACILITY STANDARDS</p>	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

ZIT621

TITLE

(X6) DATE

*8/25/06*

If continuation sheet 1 of 1